# SECTION 6
# FORMS & ATTACHMENTS

## Prior Authorization

Providers are required to seek prior authorization (PA) for certain specified services **before** delivery of the services. In addition to services that are available through the traditional MO HealthNet Program, expanded services are available to children under the age of 21 through the Healthy Children and Youth (HCY) Program. Some of these expanded services also require PA. A complete list of the HCY services can be found in Section 19.1 of the MO HealthNet Durable Medical Equipment (DME) provider manual.

The following general guidelines pertain to all prior authorized services.

- PA requests can be completed and mailed to Infocrossing Healthcare Services, Inc., P.O. Box 5700, Jefferson City, MO, 65102. Providers are encouraged to submit their PA requests by facsimile (fax) to 573/659-0207. Regardless if the PA request is mailed or faxed, providers should keep a legible copy of the original PA request form in the participant's record as the form is not returned to the provider. **Do not mail PA requests that have been faxed.** This will cause duplicate requests in the system and result in processing delays.
- The provider performing the service must submit the PA request form. Sufficient documentation or information must be included with the request to determine the medical necessity of the service.
- The service must be prescribed by a physician or nurse practitioner.
- PA requests are not to be submitted for services prescribed to an ineligible participant. State Consultants review for medical necessity only and do not verify a participant's eligibility.
- Expanded HCY (EPSDT) services are limited to participants under the age of 21 and are **not** reimbursed for participants 21 and over even if prior authorized.
- Payment is **not** made for services initiated before the approval date on the PA request form or after the authorization deadline. For services to continue after the expiration date of an existing PA, a new PA request **must** be completed and mailed to Infocrossing Healthcare Services.
- An approved PA **does not** guarantee payment.

Providers must adhere to the following criteria when submitting PA requests by fax.

- Only one PA request may be submitted per fax call. Multiple PA requests per call will not be processed as the system views multiple requests as attachments to the first request received from that call.
- Only PA requests may be faxed. Any other type of request/document (i.e., questions, certificate of medical necessity) that is faxed will not be processed.
- Do not scale down attachments in an attempt to fit multiple pages on one sheet. This causes the document to be difficult to read. Requests that cannot be read will be returned to the provider for resubmission.
- Use a business fax cover sheet when faxing the PA request. The cover sheet should include the return fax number. This will assist the return of disposition letters by fax.

Regardless if the PA request is approved or denied, the provider will receive a MO HealthNet Authorization Determination (disposition) letter containing all of the detail information related to the PA request. PA requests that are received via fax will receive a faxed disposition letter; those PA requests received by mail will receive their disposition letter by mail. For those requests received by fax, ensure the fax number from which the PA request is sent is not a blocked number. A blocked fax number will prevent the disposition letter from being returned by fax. Disposition letters that cannot be successfully returned via fax will be mailed to the provider. All other documentation submitted with the PA request will not be returned.

A request for change (RFC) to an **approved** PA must be indicated on the disposition letter and submitted to Infocrossing at the address stated above. A new PA request for changes to an approved PA should not be submitted**.** A RFC should not be submitted for PA requests with a denied (D) or incomplete (I) status but must be resubmitted to Infocrossing as a new PA request. Providers do not have to obtain a new PA request form signed by the prescribing practitioner, but may submit a legible copy of the original PA request with additional documentation as needed. In order to avoid duplication of RFCs, the following should be kept in mind.

- Do not submit a RFC if a disposition letter has not been received from the initial PA request.
- Do not submit a RFC if a disposition letter has not been received on a previous RFC for the same item.
- For participants who have or need both a power and manual wheelchair, the RFC for the accessories must state which wheelchair the accessories are for. This becomes especially important when some of the accessories have been compiled in to procedure code K0108 on both wheelchairs.
- A RFC may be submitted to correct a procedure code and/or modifier; however providers need to explain the reason a different procedure code is being requested and supply additional documentation as necessary.

PA requests and a RFC for the same participant, for the same or similar items, will be denied as duplicate requests.

Durable medical equipment requiring a PA for a purchase item will be authorized for three months; equipment requiring a PA for rental will be authorized for six months.

Instructions for completing the PA request form are found in Section 8 of the MO HealthNet *Provider's Manual* available on the Internet at http://www.dss.mo.gov/mhd/providers/index.htm. Instructions are also self-contained on the back of the PA request form.

# Certificate of Medical Necessity

The Certificate of Medical Necessity (MN) attachment should be submitted electronically. The attachment and instructions are available at www.emomed.com. Providers are required to obtain a signed MN to be retained in the MO HealthNet participant's medical record.

Section 19 of the MO HealthNet Durable Medical Equipment (DME) provider manual contains the reimbursement guidelines for covered DME items. Those items stating MNF, Certificate of Medical Necessity on File, do not have to have a MN filed to MO HealthNet. These items do require a MN be kept in the participant's file.

## General Guidelines for the MN Attachment

- The medical reason why the item, service, or supplies are needed must be stated fully and clearly on the MN attachment relating to the particular participant involved.
- The item, service, or supply must be prescribed by a physician or nurse practitioner.
- The appropriate modifier must be stated with the HCPCS code on the MN attachment.
- An approved MN attachment is valid for six (6) months from the “Date Prescribed”. Any claim received matching the criteria, including the modifier, on the MN for that time period can be processed for payment. Additional MN attachments must be obtained every six months if the participant’s medical need for the service continues.
- Medical consultants and medical review staff review the MN attachment to make a determination regarding approval of the service. Approval of the MN attachment does not guarantee payment of claims.

Information on the MN attachment can be found in Section 14.1 of the MO HealthNet DME manual available on the Internet at http://www.dss.mo.gov/mhd/providers/index.htm.

# Oxygen and Respiratory Equipment Medical Justification

An Oxygen and Respiratory Equipment Medical Justification (OREMJ) attachment completed in its entirety must be submitted electronically for oxygen and oxygen delivery systems. The OREMJ attachment and instructions for completion are located at www.emomed.com. Submission requirements for the OREMJ attachment can be found in Section 13.26.B in the MO HealthNet DME manual. Section 19.2 of the DME manual identifies those procedure codes requiring the OREMJ attachment.

The attending physician must have seen the participant in person within 30 days prior to the initial date of certification. The participant must be recertified 12 months after the initial certification. The participant must be seen and reevaluated by the treating physician within 90 days prior to the 12 month recertification. If the participant is not seen and reevaluated within 90 days prior to recertification but is subsequently seen, reimbursement may be made for dates of service between the scheduled recertification date and the physician visit date. No additional testing is required after the additional certification and no additional certifications are required after the 12 month recertification.

A revised OREMJ attachment must be submitted when the participant's treating physician changes the type of oxygen delivery system or there is the addition of a portable system to a stationary system.

The appropriate modifier must be stated with the HCPCS code on the OREMJ attachment.

The State Respiratory Consultant reviews the OREMJ attachment to determine if oxygen therapy will be approved. A prescription for oxygen that states “Oxygen PRN” or “Oxygen as needed” is not sufficient and will not be approved. Approval of an OREMJ attachment does not guarantee payment of claims.